

## BILLINGSHURST SURGERY, ROMAN WAY, BILLINGSHURST, WEST SUSSEX RH14 9QZ

**New Patient Check Form- PLEASE COMPLETE & RETURN TO THE SURGERY**

<b>Name:</b>		<b>DOB:</b>	
<b>Home Tel No:</b>		<b>Mobile No:</b>	<b>Work No:</b>
<b>Main Spoken Language</b>		<b>Ethnic Origin</b>	
<b>Has Carer: YES / NO</b>	<b>Carer Name:</b>		<b>Tel No:</b>
<b>Is Carer: YES / NO</b>	<b>For:</b>		
<b>Next of Kin:</b>	<b>Name:</b> <b>Relationship:</b>		<b>Tel No:</b>

<b>Height:</b>	<b>Weight:</b>	<b>B / P:</b>	<b>Waist:</b>		
<b>Smoker: YES</b>	Cigarettes per day =	Tobacco per day =	Cigars per day =		
<b>Smoker: NO</b>	Never smoked?	Ex-smoker?	Date Stopped =		
<b>Alcohol: YES / NO</b>	Units per week = (unit = ½ pt standard beer, 1 measure spirit, 1 glass wine – pub measures)				
<b>EXERCISE:</b> (Please tick)	Nil	Difficult	Light	Moderate	Heavy
<b>Total Cholesterol</b>					
<b>Total Cholesterol/HDL Ratio</b>					
<b>ALLERGIES Drugs</b>			<b>ALLERGIES Non-drugs</b>		
<b>Name:</b>			<b>Name:</b>		
<b>Reaction:</b>			<b>Reaction:</b>		

**CURRENT MEDICATION:**

In order for us to issue you with any medication prior to your electronic records being received, please provide the right hand (white) section of a recent prescription or alternatively request a printed list of your current medication from your previous surgery. If you are unable to provide either of these documents you will need to make an appointment with a GP in order for any medication to be added to your records.

**If you have any of these chronic diseases please indicate below and make an appointment in the appropriate clinic for your annual review:**

<b>Chronic Disease</b>		<b>Clinic to Book</b>
<b>Diabetes</b>	<b>YES / NO</b>	<b>Fasting Bloods &amp; Diabetic Clinic</b>
<b>Chronic Heart Disease</b>	<b>YES / NO</b>	<b>Fasting Bloods &amp; Cardiovascular Clinic</b>
<b>Asthma / COPD</b>	<b>YES / NO</b>	<b>Asthma Clinic</b>

**MEDICAL HISTORY (including details of past operations/investigations over the last 5 years or significant history)**

<b>FAMILY HISTORY (to only include parents)</b>	<b>Maternal (Mother)</b>	<b>Paternal (Father)</b>
<b>Cancer</b>	<b>YES / NO</b>	<b>YES / NO</b>
<b>Heart Disease Under 60</b>	<b>YES / NO</b>	<b>YES / NO</b>
<b>Heart Disease Over 60</b>	<b>YES / NO</b>	<b>YES / NO</b>
<b>Stroke</b>	<b>YES / NO</b>	<b>YES / NO</b>
<b>Diabetes</b>	<b>YES / NO</b>	<b>YES / NO</b>
<b>Asthma</b>	<b>YES / NO</b>	<b>YES / NO</b>
<b>Hypertension (Blood Pressure)</b>	<b>YES / NO</b>	<b>YES / NO</b>